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Addressing Culturally Specific Mental Health Care Needs in the US:
The Asian American Population

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Abstract

As the fastest growing minority group in the US, Asian American health needs and disparities are becoming critical areas to address, particularly in the mental health domain (Leong, Park, & Kalibatseva, 2013). Currently, the culturally specific needs of this group are not being adequately met. This includes appropriately serving low English proficiency (LEP) patients who experience different healthcare quality and outcomes than other individuals. Additionally, recognizing culturally unique perspectives, emotional burdens, and immigrant experiences is crucial in developing culturally tailored mental health interventions and shifting mental health toward individualized care. This work aims to examine current policies surrounding culturally competent care in the US, areas of critical need such as language competency, differences in cultural experience, mental health service access barriers, and current efforts/future steps to address the needs of this group.

Introduction

Demographic Shifts: Language and Minority Populations

Over the past 50 years, the United States has experienced a unique period of population shifts and growing minority population. This is particularly true of Asian Americans which saw an extraordinary increase in the last census—according to data collected during the 2010 census, the fastest growth in the Asian American population was observed in the 10-year period between 2000 and 2010. Analysis showed 43% growth in respondents reporting "Asian alone" and 46% increase in those indicating they were Asian "in combination with another race" (Hoeffel, Rastogi, Kim, & Shahid, 2012). As compared to other minority groups, the Asian American population is unique because the largest immigration wave only occurred after the 1965 Immigration Act,

meaning a significant portion of Asian Americans are foreign born (67.4%) as compared to 29.2% of Latinx individuals (Leong, Park, & Kalibatseva, 2013).

Coinciding with these demographic changes, the US healthcare system has seen increased demand, particularly in the areas of cultural competency and linguistic services. The large population of foreign born people has demanded greater access through interpretation and culturally aware accommodations. In their study, Kim, Loi, et al. (2011) referred to the population reporting speaking English less than "very well" as limited English proficiency (LEP) individuals and according to their analysis of US Census data, found that about 51% of respondents fell within this category. Given the expansive and continuously growing needs of this group, it is crucial to review the policies created to address these needs.

Overview of Public Policy

Public policy within the United States falls under multiple organizations and laws including the Department of Health and Human Service, the Civil Rights Act, and the American Psychological Association. Within the Civil Rights Act, individuals are protected from discrimination based on their "national origin" which also encompasses language. This dictates that federally funded health care organizations (those accepting Medicaid or Medicare) are required to provide linguistically competent services (Civil Rights Act, 1964). More recently, policies surrounding culturally competent care have been set forth by the Department of Health and Human Services. These are national standards encompassing "culturally and linguistically appropriate services (CLAS)" and are intended to meet the diverse needs of growing minority populations (Weech-Maldonado, et al., 2012).

The CLAS guidelines are intended to create a framework for organizations to deliver quality care to all of their patients, regardless of cultural background. These standards are broken

into different facets of the healthcare system addressing: "Governance, Leadership, and Workforce," "Communication and Language Assistance," and "Engagement, Continuous Improvement, and Accountability" (Hoeffel, Rastogi, Kim, & Shahid, 2012). Many of these sections emphasize education, training, improved access, and accountability in order to meet the diverse needs of patients in the most appropriate ways. Governance, leadership, and workforce largely focuses on organizational structure built around people in which capable leaders and employees are educated and trained on policies. This emphasizes the spread of responsibility throughout an organization sharing in the investment toward culturally competent care. Communication and language assistance aims to address access issues by notifying patients about and offering linguistic services, holding language professionals and anyone providing language assistance accountable, and providing comprehensible health information and materials. Finally, the last section focuses on critically evaluating organizations and identifying areas that require improvement. These include specific measures such as collecting demographic data, conducting assessments of organization/facility performance with the standards, and improved communication between the organization and patients, including the community as a whole (Hoeffel, Rastogi, Kim, & Shahid, 2012).

Specifically related to mental health, the American Psychological Association (APA) has a set of standards entitled "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" that aims to deliver information and logistics to psychologists regarding culture and the implications in their practice (American Psychological Association, 2003). The APA guidelines offer an interesting opportunity with the potential to address culture and language within the mental health care setting. By all accounts, this should be seen as a step in the correct direction, however there is a major distinction between the APA and

CLAS standards. While the APA outlines a *framework* for mental health care providers to act on an *individual* level, the National CLAS Standards "provide a customizable, yet *definitive*, set of actions for *organizations* to support the cultural and linguistic competency efforts" (Barksdale, Kenyon, Graves, & Jacobs, 2014). This challenges the CLAS standards and their applicability to mental health care settings in areas the APA standards do not address. To what degree are the standards that apply in general health care settings appropriate for those in mental health and how well are they executed?

With the continuing shifts in population and increased demand on the healthcare system, policies and practices must be critically evaluated to determine where health disparities continue to exist as well as how to best address those shortcomings. This is particularly true of mental health services which experience less frequent usage by Asian Americans and is not currently equipped to address the culturally specific burden of this population. I aim to focus on mental health care of Asian American individuals, their specific needs, frequency and patterns of mental health usage, patterns preventing access, low English proficiency, and future research and policies to address this issue.

Policies and Asian American Engagement in the US Healthcare System

Evaluating Current Policy

Policy Implementation in US Hospitals

The practices and standards described in the National CLAS guidelines have tremendous potential to improve patient care, however, to determine their success, they must be evaluated in practice. In a study published in 2010, Diamond, Wilson-Stronks, and Jacobs aimed to assess if hospitals are adequately meeting the National CLAS standards by conducting cross-sectional surveys to primarily determine if linguistic services were being provided in appropriate cases.

Researchers evaluated each standard individually to determine the quality of care being provided at hospitals in the United States. Previous studies were highlighted that found very few health care organizations could categorize themselves as providing sufficient linguistic services. These include lack of interpreters, signage in other languages, written services, and low patient awareness regarding their rights to language services (Diamond et al., 2010). Given the lack of comprehensiveness in previous studies, researchers aimed to evaluate the performance of each standard as well as determine preventative factors in meeting those guidelines.

Among the hospitals studied, there was considerable variation in timely delivery of language services. Variability was found to be most common for the third most frequently-requested language suggesting that populations representing a language minority among LEP patients face an even greater disadvantage. This is a concern in cases where physicians and patients may resort to inappropriate methods of translation such as family, particularly children. Although many hospitals studied had policies restricting and prohibiting family members from acting as interpreters, they were not enforced. This significantly increases risk of miscommunication or medical error.

Addressing CLAS Standard 5, the researchers found that only a small portion of hospitals provided patients with information about their rights to language services in the appropriate language, potentially rendering the initial offer pointless. One contributor to this miscommunication is lack of awareness by patients that require services, possibly due to "poorly developed and inconsistently used systems" to collect this data (Diamond et al., 2010).

Issues of interpreter quality were also discovered after determining few hospitals assess the skills of interpretive staff even though assessment tools are affordable and readily available.

Inconsistency in translation service quality can lead to miscommunication, poor health outcomes, and inefficiencies in care.

Finally, Standard 7 of the National CLAS standards was noted as a shortcoming in many hospitals with important documents being available in only one language (most commonly requested) but very few carried materials in additional languages. Delay in timely interpretation and lack of materials for minority LEP populations increases the potential for this population to receive poorer health care and also places the hospital with liability risks.

The overall evaluation of the hospital CLAS standards performance was poor and the authors suggest that even "gold standard" organizations were not adequately meeting expectations stipulated by Title VI of the Civil Rights Act. If institutions heralded as being of highest quality are not measuring up to these standards, it begs the question of how poorly other institutions are faring in serving their patients. Several barriers to providing these services were noted. Among the challenges to providing interpreter services, financial means and lack of insurance reimbursement were noted as the greatest, reported by 28% of the hospitals surveyed. Even states that offered reimbursement via Medicaid programs were not found to be more compliant than states without reimbursement. Other challenges included wait times, lack of awareness by staff in both the need for and process by which to obtain an interpreter, and shortage of interpreters (Diamond et al., 2010). These results reflect a need for staff training, increased availability of interpreters, and overall organizational investment into cultural competency and linguistically appropriate care.

Policy Implementation in Mental Health Care

A more recent study aimed to evaluate these guidelines specifically in the domain of mental health, an arguably distinct portion of our healthcare system that requires individual evaluation. These settings are crucial to study because cultural competency and linguistic services play a major

role in improving quality and access. Improved client satisfaction and perception of competent care are associated with increased usage of psychological services (Barksdale, Kenyon, Graves, & Jacobs, 2014). With the establishment of the National CLAS Standards, it is paramount to evaluate mental health care because these services and institutions have the potential to improve their outreach and quality of care significantly should they properly implement these practices. Unfortunately, significant research has not yet been conducted to appraise the guidelines in psychiatric care settings. This is perhaps negligent as studies often highlight "the inability of the mental health system to understand the cultural needs of diverse populations and adapt services accordingly" as a major factor contributing to mental health disparities (Barksdale et al., 2014). At the time of publishing in 2014, there had been just a single case study examining the implementation of the National CLAS standards in New Mexico concluding that the state has some capacity to deliver CLAS aligned care but faces barriers with data and technical issues. Unlike the study discussed above, it seems that no comprehensive evaluation of mental health systems has been conducted to ascertain strengths, weaknesses, and adherence to cultural competency standards. Barksdale et al., (2014) speculated that likely obstacles to successful implementation include poor awareness of CLAS standards and their compatibility to the mental health care settings, inadequate support from leadership, and lack of monetary resources to "support, maintain, and evaluate the Standards' adoption and implementation."

Taking into account the inadequate adherence to cultural competency standards in general healthcare settings and combining the lack of assessment in psychiatric care services, it is unlikely the national CLAS standards are being addressed in mental health settings. This poses a risk to health outcomes, quality of care, and furthering of mental health disparities. These policies should

be evaluated in the context of mental health care for Asian Americans who already face reduced usage compared to other minority populations.

Frequency and Pattern of Mental Health Service Usage

In comparison to other minority populations, Asian Americans are less likely to engage in mental health care. According to one analysis, Asian/Pacific islanders were found to be less likely than any other racial/ethnic group to report mental health service needs. Sentell, Shumway, and Snowden (2007) asserted that this was due to different cultural conceptions of mental illness and strategies to cope with such issues. As with the risk factors associated with developing mental disorders within the Asian American community, there are also generational factors that determine if individuals will seek the necessary services to treat their conditions. An investigation by Abe-Kim et al., (2011) determined that nativity status and generation status were the most influential indicators of service usage. They found that US-born individuals were more likely to utilize mental health services than their immigrant counterparts at a rate of 6.19% vs. 2.17%. Several studies have also suggested individuals from minority groups access mental health in different ways than other individuals. The point of entry for these populations is usually through a primary care provider. Not only does this create a burden on these practitioners to address initial mental health concerns/education, it also requires that these providers be familiar with appropriate mental health services to which they may refer their patients.

These patterns of mental health service usage illustrate the unique manner in which Asian Americans access their needed services and also highlights several barriers to services. Further research and policy adjustment are necessary to address these differences in access patterns for a group already hesitant to seek mental health care.

Asian American Population and Mental Health

The rapidly growing Asian population, improved cultural competency guidelines, and major disparities in healthcare for LEP individuals not only carry implications for the general health care system, but also mental health care for Asian Americans. Mental health care falls under a separate (and perhaps difficult to compare) domain than other health care services. As the US healthcare system advances toward individualized care approaches, providers, policy makers, and patients must consider how mental health care fits into this equation. While the current standards have been evaluated from a more general perspective, the unique experiences of Asian Americans engaging in mental health care must also be examined through culturally specific needs, frequency and patterns of service usage, access barriers, and how LEP plays a role in this specific system.

Specific Needs

Acculturative Stress and Discrimination

As noted earlier, a majority Asian Americans living in the US are foreign-born; with immigration comes the experience of acculturative stress. Acculturative stress entails the psychological and social difficulties encountered by individuals attempting to adapt to a new culture (Singh, Schulz, Neighbors, & Griffith, 2016). In addressing mental health needs of Asian Americans, especially immigrants, it is crucial for providers and services to recognize the implications of acculturative stress on their patients as well as the appropriate response to those challenges. Discrimination is a major contributor to stress and can lead to other, more serious mental health issues. Some studies have shown that discrimination is correlated with higher levels of depression and overall psychological distress (Leong, Park, & Kalibatseva, 2013). The DSM-IV further legitimized culturally-related psychological conditions by labeling these concerns the "Acculturative Problem" following studies that have connected acculturative stress to depression

and anxiety (Singh, Schulz, Neighbors, & Griffith, 2016). These findings carry implications for policy makers and resource providers serving immigrant populations.

Immigrant/Generational Status

Additional determinants of mental health in Asian American individuals include their immigrant/generational status or when they/their family came to the United States. There are some conflicting theories and evidence surrounding this topic with some suggesting that those immigrants who acculturate earlier are less likely to develop mental health problems while other evidence suggests that foreign-born individuals had a lower rate of psychological disorders compared to US born counterparts (Singh, Schulz, Neighbors, & Griffith, 2016). Even within families, the distinct experiences of parental cultural expectations and children can lead to interpersonal stress. A recent study by Carrera and Wei (2017) highlights generational differences, particularly in the experiences of college students. This study explored belongingness, burdensomeness, interpersonal shame, and perfectionistic family discrepancy in college students. In these cases, interpersonal shame describes the sentiment of inadequacy stemming from interpersonal concerns and perfectionistic family discrepancy describes the perception of actual performance and the incongruence with parental expectation. While these experiences are frequently and satirically highlighted in the Asian American community, the study found that these perceptions shaped outcomes. Findings suggest that perceptions in lack of belonging and burdensomeness are positively associated with interpersonal shame which subsequently may lead to higher risk of depression. Additionally, perfectionistic family discrepancy was found to augment the risk of depression correlated with a low sense of belonging.

Risk/Protective Factors

In identifying the unique perspectives of Asian Americans, it is also crucial to note that within this group lie certain risk and protective factors. These can be advantageous in implementing prevention measures as well as more effective treatment strategies. One research review found that "social networking, ethnic identity, family cohesion, and bilingualism" represent protective factors while "LEP, discrimination, acculturative stress, family conflict, and low socioeconomic status" are psychological disorder risk factors for Asian American immigrants (Singh, Schulz, Neighbors, & Griffith, 2016). The protective factors are initially counterintuitive because many may assume assimilating to a host culture would be beneficial in reducing discrimination and continued acculturative stress. Acknowledging these risk and protective factors can help to identify particularly vulnerable populations such as immigrants residing in areas without large cultural communities and social opportunities. These individuals are also less likely to have access to linguistically appropriate care and represent a greater risk for negative health outcomes.

Barriers Preventing Access

Asian Americans utilize mental health resources less frequently than other groups. Given the specific needs and risk factors associated with this group, it is imperative to understand the access barriers in order to propose effective solutions. The CDC reported in 2004 that Asian Americans suffer "disproportionately" from different diseases and noted that communication issues and cultural barriers are contributing variables. Other barriers include "insurance, stigma, racism, discrimination, differences in communication styles, and mistrust and fear of treatment" (Sentell, Shumway, & Snowden, 2007). This pattern of disease risk and hesitation to seek treatment perpetuates a cycle of negative mental health status for individuals that are already facing specific societal pressures. Those individuals that do seek care are observed engaging first with

primary care providers to discuss psychological distress, however in these instances, language barriers may restrict discussion of mental health. Further, that care provider may not be able to make referrals to linguistically skilled providers (Sentell, Shumway, & Snowden, 2007).

Financial/Insurance Barriers

Asian Americans (particularly immigrants) may face compounding factors preventing them from accessing services. In a study by Sentell, Shumway, and Snowden (2007), LEP and immigration status were associated with difficulties in obtaining health insurance—a major detraction for individuals who may consider seeking mental health support but are not of financial means to pay for it. In addition to this issue, Asian Americans are frequently perceived as being financially stable if not privileged. Statistics show a greater family income for Asian Americans but this may be attributed to the pattern of more family members contributing to household income. Additional analysis showed that certain Asian subgroups are masked based on the distribution and those groups may experience significant financial hardships (Leong, Park, & Kalibatseva, 2013). This may contribute to providers lack of concern surrounding certain groups that may be of increased risk and suffer from inadequate resources, such as specific subgroups of Asian Americans. Within these populations, absence of provider awareness may further perpetuate the issue.

Perception

The low rates of mental health service usage may be attributed to within group perception of mental health and how it should be addressed. In certain cultures, values dictate communication and responses to toward mental disorders. These may contribute to reduced willingness to disclose psychological concerns or express them publicly (Kim, et al., 2011).

Perceptions and knowledge regarding mental health within Asian American communities have been studied in educated groups such as undergraduate college students. Thapa, Sung, Klingbeil, Lee and Klimes-Dougan (2015) conducted an assessment of Asian-American attitudes and perceptions toward suicide and suicide prevention. The objective of the study was to explore how ethnic differences account for discrepancies in depression and suicide knowledge, coping attitudes, and suicide prevention attitudes of Asian Americans in comparison to their white peers. After delivering different content regarding suicide and depression to each group, researchers distributed questionnaires to assess suicide and depression knowledge as well as coping and prevention attitudes. From the questionnaire, researchers found that Asian Americans estimated a greater association between depression and suicide as well as suicide attempts and death in comparison to white participants. These findings may indicate a more normative view of suicide as a response to stressors rather than considering other outcomes as more typical. In response to questions regarding help-seeking attitudes, Asian Americans had a lower frequency of responses endorsing these behaviors when compared to the white group (Thapa et al., 2015).

Stigma

Stigma also represents a major factor in perceptions and resource access of mental health in many Asian populations. While there is a great deal of diversity within Asian cultures, many share similar values of "conformity to norms, emotional self-control, collectivism, family recognition through achievement, and filial piety" (Abdullah & Brown, 2011). These values make engaging in Western mental health care challenging for communities that conceptualize psychiatric illness in a completely different way.

Two types of stigma are recognized relating specifically to mental health: public and self-stigma. Public stigma not only affects an individual but also their friends, family, and care

providers. This stigma is correlated with discriminatory patterns such as employment and housing difficulties, and involvement in the criminal justice system. Public stigma may negatively reflect poorly on parents of children with mental illness or children of parents with mental illness (Abdullah & Brown, 2011). For Asian Americans that place high value on family and a collectivistic community, this stigma may be amplified, reducing the chances that individuals are open with their psychological concerns. In addition, the other mental health related stigma, that of the self, may be a further detriment to individuals with mental illness. This stigma “leads to automatic thoughts and negative emotional reactions; prominent among these are shame, low self-esteem, and diminished self-efficacy” (Corrigan, 2007). Specifically, for Asian Americans public stigma may increase self-stigma.

In an integrative review of cultural stigma, several patterns related to mental health were highlighted. Perceptions of mental health in Asian communities and cultures are distinct and studies found that psychological illness was viewed as "dangerous, aggressive, and unpredictable". Further, any outward expression of these traits was also considered signs of mental illness and/or "personal weakness" to people within this group (Abdullah & Brown, 2011). Following the collectivistic values in Asian cultures, psychological illness is often seen as a negative reflection the family and can be cause for shame. This may impact individuals' ability to marry and achieve occupational and academic success. In groups that place such a high value on these activities, psychiatric illness represents a greater risk for stigma.

These patterns were also reflected in a study done by Fogel and Ford (2005) that studied self-stigma in Asian Americans with depression. Researchers evaluated feelings of embarrassment and hesitancy to disclose their mental health status to friends, family, and employers. Findings indicated that in comparison to their Caucasian counterparts, Asian Americans endorsed a greater

amount of stigma (Fogel and Ford, 2005). These findings further implicate culture in relation to stigma and accessing mental health treatment. In a study by Miville and Constantine (2007), public stigma and intent to seek counseling was studied in Asian American college women. Results of the study found that cultural values and mental health service-seeking stigma were positively correlated, so the stronger the cultural value, the greater the stigma was present against seeking counseling.

Considering the numerous barriers facing Asian American access to healthcare, specifically psychological care, there is an even greater burden on research and policy to address the needs of this growing and high-risk group. Part of these changes must account for the initial barriers to mental health care access so that cycles of negative mental health and stigma do not perpetuate.

Low English Proficiency

General

One area of interest in addressing healthcare disparities is the difference in outcomes between English competent speakers and those of limited proficiency. Not only do LEP patients face access barriers, they also experience lower quality delivery of healthcare. A study by Kim, et al., noted that having limited English abilities is associated with less engagement with general health care services and further, these language barriers may lead to miscommunication and other negative effects in understanding treatments information and navigating health resources (2011). Given these complications, it is reasonable that LEP individuals are reluctant to engage in healthcare as they encounter barriers in access as well as comprehensible, quality care.

Case Study

The disparity in care is well illustrated in a study by Zurca et al., (2016) which examined LEP families in the PICU. This study found that LEP families had a lower chance of being invited to participate in medical rounds and understanding care plans following those rounds. This includes much smaller odds (~32%) of understanding care plans in comparison to English proficient families. In addition, these families had less than satisfactory evaluations of the amount of time that a bedside nurse spent speaking with them and they were also less likely to rely on said nurse to provide further explanation on their child's health condition (Zurca, et al., 2016). This data indicates lack of invitation to engage in healthcare on behalf of a child as well as limited understanding of the treatment/care being provided. Under these circumstances, LEP families are at a disadvantage in making informed decisions regarding their child's care. 82% of the LEP families indicated that the presence of an interpreter during rounds would greatly benefit their understanding of the information discussed. However, further data shows that interpreters may not represent a wholly effective solution as only 42% of those LEP families answered "Strongly Agreed" with the statement asserting "they understood the plan after a family conference," in which all families had an interpreter present for the meeting (Zurca, et al., 2016).

The issue of limited/low English proficiency is multifaceted in that it acts as a contributor to negative mental health status as well as a barrier to receiving mental health services. As discussed earlier, LEP plays a significant role in quality of care as well as outcomes in general healthcare, however within the mental health domain, the effects of limited English proficiency are amplified as psychological diagnosis and treatment rely heavily on communication as opposed to other diagnostic tests and batteries that can easily be performed through an interpreter. LEP is therefore a major contributor to the issue of quality mental health care for Asian Americans and

understanding its effects is paramount in determining if the current systems/policies in the US for addressing mental health are adequate.

"Failure to address linguistic differences in mental health service provision risks unnecessarily adding to disease burden imposed by untreated mental illness"

- L.R. Snowden et al., 2011

Contributions to Negative Mental Health Status

Emerging research suggests that LEP is being recognized as an important determinant of health behaviors including mental health and service access/utilization. These determinants are noted as key correlates for Asian American immigrants in particular. A study by Taekuchi, Zane, et al., (2007) revealed that Asian men who were less proficient in English showed greater likelihood of developing lifetime mental disorders. Similarly, Mui, Kang, Kang, and Domanski's (2007) study found the strongest predictor of mental health outcomes was language proficiency. These factors may be related to acculturative stress and can also be tied to pressures within the workplace. In professional settings where advancement toward managerial positions is desired, high English proficiency is essential—a lack thereof may take a significant toll on psychological well-being (Zhang, Hong, Takeuchi, & Mossakowski, 2012). Not only do barriers of professional advancement hinder mental health, they also add a financial burden which can further contribute to psychological distress. Low/limited English proficiency may also relate strongly to "perpetual foreigner" stereotypes that are associated with accented English. Accent is often used as a marker of "foreignness" and further adds to discrimination and distress (Zhang et al., 2012).

In acknowledging the negative effects of LEP, it is natural to consider the opportunities for English education to counter many of the aforementioned issues. While reaching language fluency would be beneficial, Leong, Park, and Kalibatseva (2013) note that "attaining English proficiency

while relinquishing one's heritage language is similarly deleterious" to mental health. In an effort to mediate one problem, another arises. Tseng and Fuligni (2000) examined immigrant parents' language differences and observed that families were less cohesive if their children were less proficient in the family's heritage language. In this particular case, linguistically competent mental care providers may provide a valuable solution in addressing psychological needs of LEP individuals.

Service Access

The other major detriment of LEP in mental health care is its representation as an access barrier. In several comparative surveys, Asian respondents reported that linguistic barriers were as important, if not more so than cultural barriers in accessing services (Snowden, Masland, Peng, Lou, & Wallace, 2011). Not only are their perceptions of these barriers significant, the corresponding rates of usage reflect a similar pattern. An analyses of Asian/PI service usage found that 56% of respondents that only spoke English received necessary mental health services compared to only 11% of Asian/PI respondents that did not speak English. Further analysis showed that the latter group had 85% lower odds of receiving treatment than their English-speaking counterparts (Sentell, Shumway, & Snowden, 2007). Although not explicitly discriminatory, LEP individuals are essentially excluded from psychological services simply because of communication barriers.

Moving Forward

Improvements in Research

As medicine and healthcare become increasingly personalized it is evident that research into Asian American mental health care has a long way to go. Moving forward in research will

require identifying limitations, considering the possibility of culturally tailored interventions, and assessing the shortcomings/potential directions for research.

Much of the research conducted, particularly regarding mental health care and conceptions of how psychiatric disorders manifest, usually occurs within the framework of Western medicine. While resources such as the DSM are useful in standardizing diagnostic criteria, researchers have attested that due to the "unique ways of expression" of mental health disorders in Asian American, disease occurrence rates may be underestimated (Leong, Park, & Kalibatseva, 2013). Goals to implement effective cultural competency guidelines may only be achieved by correctly measuring the scope of the issue. It would be negligent to implement policies regarding psychological care and practices specifically for the Asian American population without first understanding their conception of mental health.

In addition, there are some areas of research that seem to be lacking. While the role of LEP has been identified in both contributing to psychological distress and as a barrier to receiving services, more research must be conducted. Snowden, Masland, Peng, Lou, & Wallace (2011) observed success of international initiatives making strides in raising awareness and improving understanding of mental health, however, they have not adequately addressed the importance of language in addressing mental health service usage. Other areas of research outside of LEP should also be considered. Evaluating cultural competency often focuses on linguistic services as a benchmark. While this is a critical domain in mental health care access, it does not address all the issues/barriers related to accessing mental health, nor does it fully encompass the provision of culturally competent care. Linguistic services are a single facet of cultural competency and more comprehensive study should be conducted to evaluate organization/provider knowledge, awareness, and training on providing this quality care. Further study should evaluate how policies

and healthcare organizations aim to eliminate financial barriers, address stigma, and change perception of mental health care in Asian American communities.

One major consideration that must also be made is the format in which mental health treatment is conducted. While an interpreter may be highly beneficial in traditional healthcare settings, the benefits and challenges of those interactions may be completely different from a psychological care perspective. The value of multi-lingual health care providers should be evaluated to determine their impact on the health care system and if there should be incentives to pursue a mental health profession in addition to linguistic training. Research conducted by Diamond, Wilson-Stronks and Jacobs (2010), noted, "Bilingual physicians who can provide care in the patient's language and access to professional interpreters as opposed to the use of family, friends, and other untrained interpreters, have been shown to improve care delivery to LEP patients." Especially within the mental health care domain in which diagnosis and treatment are conducted heavily through verbal communication, the role of interpreters and bilingual providers should be examined.

Culturally Tailored Interventions

In an effort to provide the highest quality of care to patients, individual needs and personalized treatment are coming to the forefront of the healthcare industry. However, this growth has not necessarily expanded to mental health care, particularly that of Asian Americans. Some evidence suggests that their status as a "model minority" has led to the understudying of Asian American psychological needs (Ghosh, 2003). Traditional therapies typically practiced within the mental health field are not necessarily effective in addressing the needs of Asian Americans. Wong, Wilder, Schock, and Clay (2004) asserted that "inherent concepts of psychotherapy may conflict with...cultural expectations" and traditionally, those conflicts are overlooked. The perception of

these treatments plays an important role not only in their use but also effectiveness. Asian American perception of conventional therapies were reported as "ineffective, costly, intrusive, and time consuming" and many of those same respondents would prefer "directive, structured, problem-solving approaches" that prioritize symptom alleviation (Park & Bernstein, 2008).

A 2016 study by Bernstein, Park, Hahm, Lee, Seo, and Nokes introduced a culturally tailored intervention for Asian Americans focusing specifically on Korean American women with depression. Women were assessed for depressive symptoms using the Korean version of the Center for Epidemiologic Studies Depression scale were delivered either a traditional intervention or a culturally tailored program. From this perspective, simply tailoring psychological interventions may not be effective. Results found the experimental group had significantly reduced scores for depressive symptoms compared to the control group in post-tests and 3-month follow-up assessments. These findings suggest that not only is the culturally-tailored intervention successful immediately after conclusion but may have long-term effectiveness in reducing depression and increasing cognitive coping (Bernstein et al., 2016). While developing interventions from a foundation of culturally oriented care may provide the best option for delivering quality mental health treatments, this study shows the value and efficacy of culturally tailoring already-developed traditional mental health interventions. Integrating past research on culturally specific risk and protective factors may also inform effective interventions.

Overall, there are a multitude of directions in which research may be taken, however one resounding conclusion is that much more research must be conducted. In order to lay the groundwork for positive change and policy implementation, a concentrated effort must be made to improve the research surrounding this topic. Addressing the shortcomings in research such as the limitations of DSM diagnosis and the Western focused view of mental health will be integral

in understanding how specific cultural groups both experience psychological distress as well as respond to treatment.

Policy Change

The current practices for addressing the Asian American population in the mental healthcare domain remain inadequate, especially considering the projected growth of this group within the next 30 years. The specific psychological needs, barriers to access, and linguistic challenges all contribute to the cyclical decline of an already underserved group. Only after analyzing the particular needs of that group can appropriate changes and policies be implemented to mediate these factors. Other countries with rapidly growing immigrant populations have studied these groups and observed similar patterns. Their research and actions may be valuable in considering how the US should move forward. It is important to note this research is far from recent with studies as far back as 1993. These studies found that countries with identifiable immigrant health policies that emphasize cultural competency, particularly language, had greater immigrant health service access (Bollini, 1993). The robust collection of research related to countries with high Asian American populations can inform future US policy and serve as a framework within which successful changes may be made.

Surveys conducted in Europe directly addressed immigrant perspectives on these issues reporting that migrants felt mental health care professionals "underestimated language problems" and consequently, language difficulties precluded aggression and paranoia toward providers (Carta, Bernal, Hardoy, Haro-Abad, & the "Report on Mental Health in Europe" working group, 2005). Given the strong evidence that limited language ability is detrimental to healthcare engagement, developing language policies may offer an effective solution. One emerging effort to address this issue within the US are state-level "threshold language" policies. Compared to the CLAS

guidelines, these efforts focus exclusively on language services. These policies mandate the facilitation of health services in an individual's primary language if that language group exceeds a certain threshold. While these policies have not been implemented at a national level, their operation at the state level may inform what a national policy may look like.

Examining Threshold Language Policy in California

One area of the United States that implemented threshold language policies was California and subsequently, they were studied in the mental health care context. In contrast to the CLAS standards, these policies provide a definitive framework for language policy implementation rather than a suggested blueprint. In a study by Snowden et al. (2011), California threshold language policies were evaluated in the context of access to mental health treatment. Researchers found that, although modest, these policies definitively impacted rates of psychiatric service use by LEP Asian Americans (specifically those enrolled in Medicaid). They also found that desirable responses to these policies were stronger in counties that offered cultural competency training and language-specific clinics as opposed to those without these resources (Snowden et al., 2011). This suggests that language policy alone is not as effective as a multi-dimensional effort involving cultural awareness and specific service availability. Interestingly enough, the study discovered that some counties (specifically those that did not meet the threshold) already offered language assistance services. Community engagement may also inform the structure of US policy to create programs that operate beyond the healthcare setting and involve whole communities.

Evaluation and Enforcement

Two major policy areas that need to be addressed are evaluation and enforcement. While many of the CLAS guidelines may be part of a healthcare organization's policy, it does not guarantee these practices are followed. Without monitoring and assessment, the efficacy of these

policies, including areas that require improvement, cannot be addressed. Examining other countries with similar populations and how they have handled these issues will be useful in determining how the US can progress. In Canada, Ontario's Ministry of Health and Long-Term care has aimed to address the issue of immigrant health through an evaluation policy called the health equity impact assessment (HEIA). This assessment is intended as a tool to reduce health inequities and evaluate how a "program, policy, project, or initiative will directly or indirectly impact marginalized population groups" (Pottie, et al. 2018). The Ontario HEIA directly parallels issues of Asian American access to mental health care services because they could be considered a marginalized population group within the US mental health care system.

The efficacy of the tool was assessed in one study with findings carrying several implications for policy changes. Researchers found that challenges in integrating migrant perspectives were most heavily concentrated in cultural and linguistic areas. Similar to the assessment of threshold language policy, research into the Canadian HEIA found that community engagement is an integral part of reaching minority populations describing "local immigrant partnerships" as an "untapped resource with the potential to support practitioners and health professionals" (Pottie, et al. 2018). While this study successfully evaluated the strengths and weaknesses of the program, it also has potential to shape future policy within Canada. Such changes may influence design of future programs that successfully meet the needs of everyone engaging in the health care system. Assessing if and how healthcare systems address patients is paramount in creating informed and effective policy. This Canadian example aligns with future changes that could be made in the United States to improve care and outreach for Asian Americans in mental healthcare.

The overall direction in policy should focus on assessment of programs and organizations, ensuring that policies are informed and equitable. Standardization of data collection of language preferences and cultural competency education must be considered. Third, enforcement and accountability should play a major role in successfully integrating these policies. This may incorporate stricter standards by the Joint Commission on Accreditation of Healthcare Organizations to ensure that all patient needs are being adequately met. Reducing access barriers represents the most important policy changes that should be implemented regarding Asian American engagement in mental healthcare. This includes mediating financial barriers, combating stigma, changing perceptions, and addressing language restrictions.

Conclusion

As the Asian American population within the United States continues to grow, policy makers and healthcare providers must critically evaluate their needs as well as barriers to care. In combination with this rapid growth, Asian Americans represent a population that traditionally underutilizes psychological services. Cultural competency and language guidelines aim to address the disparities within the system such as poorer health outcomes for LEP individuals and access barriers faced by certain populations, however these practices are currently insufficient.

Much more must be done to address culturally specific psychological and access barriers, as well as create policies and treatments that are effective in providing quality mental health care for this group. Particular focus must be placed on access barriers such as communication, reducing stigma, changing perceptions of psychological illness, and alleviating cost burden. These factors represent an interconnected group of barriers, however in addressing one we may also address the others. Culturally tailored interventions have already shown efficacy in certain Asian populations and even greater investment can be made to address their specific needs. By incorporating Asian

American perspectives to both outreach and treatment, more of this group may engage with psychological health services, further reducing stigma surrounding mental health. Community public health initiatives have also proven effective in encouraging Asian American participation within this system and may promote longer lasting involvement beyond individual treatment.

Moving forward, it is crucial to promote accurate data collection, examine how similar nations with high immigrant populations have handled these issues, and invest in research within the United States. Not only must the US healthcare system critically evaluate its own standards for culturally and linguistically competent care, it must enforce their policies in all domains, especially within mental health. Through evaluation tools and policies that incentivize quality healthcare delivery for underserved populations, the US can reduce health disparities for at-risk populations. Accountability will be the driving force in providing high quality health care for all.

With the Asian American population only expected to grow in the coming years, addressing cultural competency within the mental health care domain is paramount. Neglecting this issue would be highly deleterious to both the Asian American population and the country as a whole. The United States is currently stagnant in serving Asian American mental health needs. With innovative research, policy development, and accountability the United States may reduce health disparities and inequities for not only Asian Americans, but all minority groups that are currently underserved by our healthcare system.

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